STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157523	A. BUILDING _____ B. WING _____	C 10/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEDIATRIC INFANT & FAMILY HOME HEALTH CARE SPECIAL	**1512 BURR ST GARY, IN 46406**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 000	INITIAL COMMENTS This was a federal home health complaint investigation. Complaint #: IN00138071 - Unsubstantiated: Lack of sufficient evidence. Survey Date: 10/24 - 25/13. Facility Number: 10192. Medicaid Number: 200156590A Surveyor: Janet Brandt, RN, PHNS Pediatric Infant & Family Home Health Care Specialists Inc. is in compliance with the Conditions of Participation 484.10: Patient Rights, 484.18: Acceptance of Patients, Plan of Care, and Medical Supervision, and 484.30: Nursing Services as related to this complaint. Quality Review: Joyce Elder, MSN, BSN, RN October 29, 2013	G 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE